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ABSTRACT

The North Carolina State Legislature made outpatient commitment (OPC) criteria less restrictive than involuntary hospitalization criteria, provided an enforcement mechanism, gave facilities and staff immunity from liability, and allocated funds for OPC patients. Data collected in a state-wide study of civil commitment respondents in North Carolina were used to evaluate the effectiveness of OPC as a less restrictive alternative to involuntary hospitalization. Analysis was limited to civil commitment respondents who were chronically mentally ill, had refused psychiatric medication, and had histories of prior hospitalization and prior dangerousness. This study compared 6-month outcome data for those who were court-ordered to outpatient treatment with those who were released and those who were committed to the hospital. Multiple outcome measures indicated that respondents ordered to outpatient treatment were as well off as respondents who were released and those who were initially committed to the hospital; and they were significantly more likely to use aftercare services and to continue in treatment. The findings suggest that outpatient commitment is an effective, less restrictive alternative to inpatient commitment for dealing with the chronically mentally ill who revolve in and out of courts and mental hospitals. (Author/NB)

EVALUATION OF A NEW THRUST IN THE DELIVERY OF MENTAL HEALTH SERVICES: OUTPATIENT COMMITMENT

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ABSTRACT

Data collected in a state-wide study of civil commitment respondents in North Carolina are used to evaluate the effectiveness of outpatient commitment as a less restrictive alternative to involuntary hospitalization. Analysis is limited to civil commitment respondents who are chronically mentally ill, have refused psychiatric medication and who have histories of prior hospitalization and prior dangerousness. The North Carolina State Legislature designed outpatient commitment to deal with this group of patients. We compare six month outcome data for those who were court ordered to outpatient treatment with those who were released and those who were committed to the hospital. Multiple outcome measures indicate that respondents ordered to outpatient treatment were as well off as respondents who were released and initially committed to the hospital; and they were significantly more likely to utilize aftercare services and continue in treatment. Outpatient commitment is, thus, an effective less restrictive alternative to inpatient commitment for dealing with the chronically mentally ill who revolve in and out of courts and mental hospitals.

Civil commitment law has seen dramatic changes in the past two decades. Essentially the law has rejected the old medical model which allowed involuntary hospitalization when there was a need for treatment and replaced it with a legal model emphasizing due process and limiting involuntary hospitalization to the mentally ill who are dangerous (Hiday and Markell, 1981; Gove et. al., 1985). Although the state's power to involuntarily hospitalize individuals still rests on both parens patriae and police power, reform statutes rejected a purely paternalistic model bringing the state's protective function to the fore. The law's rejection of paternalism as the basis of commitment was attacked by a number of mental health professionals (Abramson, 1972; Stone, 1975); but the majority of psychiatrists came to approve the new restrictive procedures and standards (Kahle et al., 1978). Criticism, however, has persisted. One criticism has been the inability of the reform law's dangerousness criterion to deal with a certain needy group, the chronically mentally ill who are not yet dangerous but on their way to becoming so.

To meet the dangerousness criterion a mentally ill person has to exhibit some dangerous behavior within a recent period prior to his commitment. Thus, a chronically mentally ill person who fails to obtain or continue treatment on his own, who then decompensates and exhibits bizarre behavior, cannot be civilly committed until he does something dangerous even though he has a history of becoming dangerous in the later states of decompensation. Family, friends, mental health professionals, and courts have to sit by and wait for him to threaten, attempt, or complete an act which could result in harm before civil commitment can be used to restrain and force him back into treatment. Where such persons used to be hospitalized for indefinite treatment, they have

revolved, since civil commitment reform, regularly in and out of both courts and state mental hospitals. Once involuntarily hospitalized and stabilized on medication, they no longer meet the dangerousness criterion for commitment. Soon after release, however, they stop taking their medication and stop going for treatment which predictively leads to decompensation, bizarre behavior, and eventual dangerousness. To reduce their chances of becoming dangerous and requiring involuntary hospitalization, a few states have recently established outpatient commitment (OPC) which allows the state to intervene with this "revolving doors" group by compelling treatment in the community before they become dangerous.

From their initiation, most reform civil commitment statutes provided for outpatient commitment either implicitedly or explicitedly (Keilitz and Hall, 1985). Indeed, some state statutes and federal appellate courts required the least restrictive alternative be used in civil commitment cases; and OPC is clearly less restrictive than involuntary hospitalization (Chambers, 1972; Hiday and Goodman, 1982). Although OPC can protect the individual and/or society by insuring treatment which will prevent decompensation and dangerous behavior, it seldom has been employed (Hiday and Scheid-Cook, 1987; Hiday and Goodman, 1982; Miller, 1985). Four problems account for OPC's neglect: 1) identical criteria for outpatient and inpatient commitment; 2) lack of enforcement provisions; 3) liability and control concerns about severely pathological persons who are dangerous (Appelbaum, 1986); and 4) lack of knowledge of OPC provisions (Miller, 1985).

Setting

The North Carolina state legislature, after a decade under reformed civil commitment, made outpatient commitment criteria less restrictive than involuntary hospitalization criteria, provided an enforcement mechanism, gave

facilities and staff immunity from liability , and allocated funds for OPC patients. Where involuntary hospitalization requires mental illness[1] and dangerousness, OPC requires:

1. mental illness;
2. capacity to survive safely in the community with available supervision from family, friends, or others;
3. treatment history indicative of need for treatment in order to prevent further disability or deterioration which would predictably result in dangerousness...; and
4. current mental status or the nature of the illness limiting or negating ability to make an informed decision to seek or comply voluntarily with recommended treatment (N.C.G.S. 122C-262(d)(1)(1985)).

The court can also order OPC when the more stringent criteria for involuntary hospitalization, mental illness and dangerousness, are met. That is, if a mentally ill person becomes dangerous the court can order OPC instead of involuntary hospitalization if the OPC criteria are met.

The law holds the court designated primary clinician responsible for making all reasonable effort to obtain patient compliance. If such effort fails, the primary clinician may request the court to bring in the patient for examination and hopeful persuasion to compliance. If a patient still refuses to comply, he can be brought back to court for review of his reasons for noncompliance or can be let alone until he exhibits some dangerous behavior, at which point a new civil commitment petition can be filed for involuntary hospitalization.

The legislature encouraged community mental health centers to use OPC by allocating money to a center for each patient it supervised and treated on

OPC. Additionally, The Division of Mental Health, The Administrative Office of the Courts, and The Institute of Government encouraged OPC by giving regional workshops and mailing circulars both before and after the OPC provision went into effect on January 1, 1984.[2]

This paper evaluates the use and effectiveness of OPC in North Carolina with the chronically mentally ill who have a history of medication refusal and dangerousness. It does not evaluate OPC as a less restrictive alternative for all civil commitment respondents but only as a less restrictive alternative for "revolving doors" patients of both courts and hospitals. It compares six month outcomes for "revolving doors" patients ordered to OPC with those ordered released and those involuntary hospitalized

Sample

The data on OPC come from a larger study of 1226 allegedly mentally ill, adult respondents to initial civil commitment hearings between July 1984 and June 1985, in all but the Western Region of North Carolina. We excluded the Western Region because of time and money costs in getting to its distant counties and because previous studies indicated it to be no different in civil commitment respondents and court dispositions than the other three regions of the state. We excluded minor, inebriate, and recommitment respondents because their histories and management are quite different.

We used stratified cluster sampling of all those hearings in counties with state mental hospitals (approximately 80% of all civil commitment hearings) and in four counties with local inpatient facilities holding civil commitment respondents. These four counties included one urban county (SMSA center) and two rural counties with CMHC inpatient units. and one urban county (part of a SMSA) with a university medical center having both inpatient and outpatient units. Selection of the larger sample ceased in January 1985, but

less frequent use of OPC than expected[3] necessitated our disproportionately sampling OPC respondents through June 1985 in two counties (one with a state mental hospital and one with a local inpatient unit) which consistently ordered OPC.[4]

Federal, state, and university regulations required that we obtain informed consent from respondents in order to gain access to their hospital and CMHC medical records for the follow-up. We attempted to approach all 1226 respondents in the hospitals in which they were held pending hearings to explain the research and obtain informed consent. Approximately 25 percent of respondents could not be contacted for a variety of reasons; only 9 percent refused, leaving 740 consenting to participate in the follow-up research.[5].

Basic demographic, illness, and dangerousness information was collected from court records at the time of sampling on all 1226 respondents[6]. Six months after their hearings,[7] we attempted to follow all respondents who gave informed consent in three ways: 1) record checks in community mental health centers in their home counties,[8] 2) record checks in the mental hospitals where they were first contacted and of their catchment areas, and 3) telephone interviews with either respondents personally, a relative/friend at their home, or someone they named who would always know where they were. Additionally, we checked court records for arrests of all respondents (not only those who consented) in their home counties. We attempted additional follow-up of all consenting OPC respondents (161) prior to the six month mark: interviewing them and their primary clinicians between one and two months following the OPC orders.

For the analysis in this paper, we consider only those civil commitment respondents for whom the new OPC criteria were designed, the chronically

mentally ill, "revolving doors" population who go off medication and become dangerous. We operationalize this target group as follows:

1. severe mental illness: diagnosis of schizophrenia, paranoia, affective disorder, or other psychosis;
2. chronicity: one or more prior hospitalizations;
3. prior dangerousness: one or more dangerous actions prior to key commitment proceeding; and
4. medication refusal: noncompliance with medication regimen immediately prior to key commitment proceeding.

Out of the total 1226 civil commitment respondents on whom we collected court data, 168 (13.7%) meet these four criteria of being members of the OPC target group. We obtained informed consent from 101 of them (60.1%)[9] and followed all but 3 of them 6 months after their hearings through their hospital records. We followed all but 4 of them through their community mental health center records, but we were able to reach only 36 directly by phone and only an additional 32 relatives/friends for a total of 68 telephone contacts. This represents 67.3 percent of the target group, a respectable proportion given their low socioeconomic status and mental conditions. Because of variation in follow-up coverage by source, the N of each outcome will necessarily vary.

Court disposition of this target group was not always OPC. A slight majority (50.8%) were ordered to involuntary hospitalization; a few (7.1%) were released; and even fewer (1.8%) received voluntary hospitalization, leaving 41.1% ordered to OPC. A much smaller proportion of the total sample was ordered to OPC (24.1%), indicating that psychiatrists and judges are attending to the new criteria and utilizing OPC more for the target group. Since target group members released are so few, caution should be taken in generalizing from results on them.[10]

Table 1 presents the characteristics of target group respondents and breaks those down by court decision. Respondents are heavily male, nonelderly, nonwhite, single, of low education and employment levels, from rural and small towns, and were dangerous in the week prior to becoming civil commitment respondents. Family members, especially children and parents, tend to be the persons petitioning for their commitment. In these respects, target group members are similar to other civil commitment respondents. It is in the last three characteristics that target group members are different. They are more likely to have a diagnosis of schizophrenia, to have 3 or more previous hospitalizations (17.0% had 8 or more), and to have 3 or more previous episodes of dangerous behavior (10.0% had 8 or more). Among target group members no significant differences in these characteristics exist between those ordered to OPC and those released or involuntarily hospitalized.

Outcome

We first consider the most restrictive residence where the target group members lived during the six months after their hearings (Table 2). Data from telephone interviews with respondents themselves and their relatives/friends indicate that the "revolving doors" population assigned to OPC are more likely to be living at home alone or with family/friends (40.7%) than those ordered to involuntary hospitalization (34.1%) or released (25.0%); however, those ordered to OPC were also more likely to be institutionalized in a mental hospital or nursing home than those who were released. Data from medical records indicate that the overwhelming majority of the target group did not become rehospitalized. Among those who became rehospitalized, most were involuntarily admitted (not shown in table). Those ordered to OPC were more likely to return to the hospital once (28.9% as opposed to 18.2% for those released and 16.3% for those involuntarily hospitalized), although not as

likely to return more than once (5.3% as opposed to 9.1% of those released and 14.3% of those involuntarily hospitalized). These differences in rehospitalization are not statistically significant, indicating that OPC is not producing more hospital admissions for the target group. Days hospitalized after key release are also not significantly different for the three groups.

In terms of functioning, OPC respondents fare well compared to other respondents. As one would expect of this population, most were not working at the 6 month follow-up; but those ordered to OPC were more likely to work than those ordered to involuntary hospitalization or released. Work here includes parttime work, school attendance, and work at home as well as full time work outside the home. Weekly social interaction outside the home and outside work as reported by respondents themselves are also greater for members of the target population ordered to OPC. They average more visits, phone conversations, and attendance at group functions than do those released and involuntarily hospitalized.

From medical records, we see that only a small proportion of the target population exhibited any dangerous behavior (attacks, threats or unintentional harm to self, others, or property) during the 6 months after their court hearings; and an even smaller proportion were arrested in the six months. OPC respondents are not significantly different from others. Thus, we see that the chronic, "revolving doors" mental patients placed in the community on OPC are not likely to threaten or cause disruptions; thus, they need not be deprived of their liberty in order to protect the community or themselves.

Most of the target population went to the community mental health center after their hearings; but those ordered to OPC were significantly more likely to attend more often and were significantly more likely to be still in

treatment at the 6 month follow-up despite the fact that most of their court orders expired and were not renewed after the first three months. The majority of target group members refused medication at least once during the six month period, not a surprising fact given their histories and membership in the target population. Those ordered to OPC were less likely than those released and no more likely than those involuntarily hospitalized to refuse medication; but OPC respondents were less likely to have other forms of noncompliance such as failure to meet an appointment without rescheduling, failure to attend a prescribed program, or failure to follow a specified course of action. Given that OPC respondents overwhelmingly remained in treatment for 6 months indicates that their medication refusal and other noncompliance was overcome or minimized. In terms of inducing compliance with aftercare services and directives, OPC is clearly successful.

The results presented in Table 2 are an understatement of the effects of OPC because some respondents ordered to OPC never actually experience it. Some members of the target population ordered to OPC are immediately sent back to the hospital with a new petition for commitment. They arrive in the community with symptoms too florid to function or they become dangerous shortly after their arrival; hence, their family or mental health professionals petition to rehospitalize them involuntarily. Some never appear at the community mental health center; thus, they never begin treatment. Separating OPC respondents who began OPC at the community mental health center--that is who had at least one visit on OPC[11]--, permits better observation of the impact of OPC (Table 3). On almost every outcome measure, members of the target population who began OPC fare better than the entire group ordered to OPC. The true or real OPC target group has higher rates of living at home, weekly social interaction, treatment at the mental health center, and lower rates of mental hospitalization, dangerous behavior,

medication refusal, and noncompliance. There are no differences in work or arrests.

Summary and Discussion

Since deinstitutionalization opened the backdoors and closed the front doors of state mental hospitals (Goldman and Morrissey, 1985), the chronically mentally ill have been more and more among us. In recent years, particularly as the homeless have gained attention, new movements both inside and outside the mental health system such as the Alliance for the Mentally Ill, have arisen to attempt to provide for this population. As difficult as it is to maintain and treat the chronically mentally ill in the community, it is even more difficult to maintain and treat that subgroup who are not only chronically mentally ill but also dangerous because they refuse to accept treatment. The new OPC provisions of a few states are an innovative attempt to maintain and treat them in the community--without their revolving in and out of the doors of courts and mental hospitals.

Our study, while having small numbers in some outcome measures, shows the new provisions of OPC to be a success with this "revolving doors" group. When the chronically mentally ill with a history of medication refusal and recurrent dangerousness are ordered by the court to outpatient treatment and they begin that treatment, they tend to remain in treatment for six months even without continued court orders, tend to have more social interaction outside the home, tend not to be rehospitalized and tend not to exhibit dangerous behaviors. OPC is thus a viable less restrictive alternative to involuntary hospitalization.

On the other hand, not all members of the target group have the opportunity for outpatient treatment. They are involuntarily hospitalized or simply released. And, .e members of the target group who are ordered to OPC

never experience OPC. They never report to the community mental health center or have to be sent back to the hospital almost immediately because they are not stabilized at discharge. From this perspective, OPC is not operating in the manner in which it was intended. Insuring an initial visit to the community mental health center to begin OPC would improve the odds of community maintenance without dangerous episodes and with less social isolation. Insuring that OPC orders are issued only when patients are stabalized on medication, would raise the success rates on outcome measures; but such insurance is not easy given these patients' unwillingness to take medication and their devices for not taking it during hospitalization (from respondent interviews).

While some OPC patients dutifully report for their initial OPC visit and comply with treatment because of the authority of the court, others require greater effort on the part of mental health centers to overcome their resistance. Those centers which had the most success with OPC carried out their obligation to solicit compliance by aggressive case management. They created new positions or hired new personnel to monitor and supervise OPC respondents; to keep contact with the state mental hospital, courts, and sheriff; to make home visits; and to provide whatever necessary services OPC respondents needed to be maintained in the community. Not all of these centers were rich in resources and programs; but they aggressively reached out to OPC respondents. They offered whatever services they had and found other community programs to supplement what they lacked. They found housing, transportation, part time work, full time employment, training, schooling, recreation, child care, and money for medication. With recalcitrant patients, they also employed the reminder that involuntary hospitalization was the ultimate alternative. Clinicians at these centers credit both aggressive case management and the threat of rehospitalization for OPC success.

FOOTNOTES

1. In North Carolina civil commitment also applies to two other groups: 1) substance abusers and 2) the mentally retarded who are dangerous to others because of accompanying behavior disorders.
2. While N.C. was the first to innovate with new standards and procedures for OPC, Hawaii and Arizona have become trailblazers along with North Carolina in this effort. As of 1985, the statutes of twenty-six states and the District of Columbia included explicit provision for OPC; New York's statute allows commitment to a hospital only; while statutes of the other 23 states do not explicitly prohibit commitment to outpatient treatment (Keilitz and Hall, 1985).
3. In a preliminary study of civil commitment psychiatric examinations at state mental hospitals, The North Carolina Mental Health Study Commission projected that 500-800 nondangerous mentally ill would be recommended for outpatient commitment from the four state mental hospitals (unpublished data, personal communication with Lynn Gunn).
4. The new provisions allowed OPC without involuntary admission to a hospital for evaluation. We planned to sample from such OPC respondents in the counties not containing state mental hospitals; but this procedure was essentially not used. All but 2 OPC respondents were first involuntarily admitted to a hospital before their court hearings.
5. Reasons for nonconsent were analyzed for a large subsample. Bias was found only by age, with the elderly being more likely to be nonconsenting largely because of their greater likelihood of being incompetent. Detailed analysis of nonconsent can be found in Scheid-Cook et. al., 1986.

6. At the court in one state mental hospital, the judge did not allow access to court records without consent; thus, Time 1 data could be collected only on those whom we could contact and who gave consent. There were no significant differences between Time 1 characteristics of respondents at this hospital and those elsewhere; however, there were fewer respondents at this hospital given OPC than at other hospitals.
7. Six months was chosen as the follow-up point because most readmissions to mental hospitals occur within that time period (Angrist et. al., 1968; Goldstein et. al., 1978; Haupt and Ehrlich, 1980; Pasamanick et. al., 1967). Furthermore, any person released or given OPC when he was mentally ill and dangerous would have ample time for the dangerous behavior to reappear and to be recommitted or jailed. With shortened hospital stays, most persons who were involuntarily hospitalized would have time to complete their stay and return to the community.
8. The outpatient clinic at the university hospital in our sample is included here.
9. This is essentially the same proportion who gave informed consent in the larger sample. Bias by consent in the target group was found only by prior hospitalization; those having been hospitalized 3 or more times were significantly more likely to give informed consent.
10. The three target group members ordered to another alternative (nursing home, voluntary hospitalization) are excluded from outcome analysis.
11. Information from primary clinician interviews.

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TABLE 1. RESPONDENT CHARACTERISTICS BY COURT DECISION

	Release		OPC		IVH		TOTAL	
	N (12)	%	N (69)	%	N (84)	%	N (165)	%
Sex								
Male	7	7.9	40	44.9	42	47.2	89	100.0
Female	5	6.7	28	37.3	42	56.0	75	100.0
Age								
<30	4	9.3	21	48.8	18	41.9	43	100.0
30-60	8	7.1	47	42.0	57	50.9	112	100.0
>60	0	0.0	1	10.0	9	90.0	10	100.0
Race								
White	6	12.0	16	32.0	28	56.0	50	100.0
Black/Other	6	5.4	52	46.4	54	48.2	112	100.0
Marital Status								
Married	1	3.8	11	42.3	14	53.8	26	100.0
Single	10	11.5	34	39.1	43	49.4	87	100.0
Sep/Div/Wid	1	2.4	19	45.2	22	52.4	42	100.0
Education								
<12	3	13.0	10	43.5	10	43.5	23	100.0
High School	2	6.7	17	56.7	11	36.6	30	100.0
Some College	5	33.3	7	46.7	3	20.0	15	100.0
Employment								
No	9	14.1	28	43.7	27	42.2	30	100.0
Yes	2	6.7	12	40.0	16	53.3	64	100.0
Town Size								
<1000	3	4.8	26	41.9	33	53.2	62	100.0
1000-2499	0	-	2	100.0	0	-	2	100.0
2500-4999	2	20.0	3	30.0	5	50.0	10	100.0
5000-9999	1	11.1	4	44.4	4	44.4	9	100.0
10000-24999	3	18.7	8	50.0	5	31.2	16	100.0
25000-49999	2	6.9	15	51.7	12	41.4	29	100.0
50000-99999	0	-	3	60.0	2	40.0	5	100.0
>100000	1	3.4	8	27.6	20	69.0	29	100.0
Recent Dangerousness								
No	4	8.3	24	50.0	20	41.7	48	100.0
Yes	8	6.8	45	38.5	64	54.7	117	100.0

TABLE 1 continued

	Release		OPC		IVH		TOTAL	
	N (12)	%	N (69)	%	N (84)	%	N (165)	%
Petitioner								
Spouse	—	0	4	40.0	6	60.0	10	100.0
Child/Parent	6	7.5	33	41.3	41	51.3	80	100.0
Other Relative	1	4.2	9	37.5	14	58.3	24	100.0
Friend/Neighbor	—	—	1	100.0	—	—	1	100.0
Law Officer	—	—	3	42.9	4	57.1	7	100.0
Social Service	—	—	3	50.0	3	50.0	6	100.0
MD	3	13.6	10	45.5	9	40.9	22	100.0
Other	1	7.7	6	46.2	6	46.2	13	100.0
Primary Diagnoses								
Schizophrenia	9	7.0	59	45.7	61	47.3	129	100.0
Other	3	8.3	10	27.8	23	63.9	36	100.0
Prior Hospitalization								
1	1	2.4	19	45.2	22	52.4	42	100.0
2	4	13.8	13	44.8	12	41.4	29	100.0
≥3	7	7.4	37	39.4	50	53.2	94	100.0
Prior Dangerousness								
1	2	3.3	30	49.2	29	47.5	61	100.0
2	3	14.3	9	42.9	9	42.9	21	100.0
≥3	7	8.4	30	36.1	46	55.5	83	100.0

TABLE 2: SIX MONTH OUTCOME[@] OF TARGET GROUP

	Release (N=11)		OPC (N=38)		IVH (N=50)	
	N	%	N	%	N	%
Residence [1, 2]						
Home (with family, friends, alone)	2	25.0	11	40.7	14	34.1
Group Home	3	37.5	1	3.7	6	14.6
Institution (mental hospital, nursing home	2	25.0	14	51.9	21	51.2
Jail	1	12.5	1	3.7	0	1.1
TOTAL	8	100.0	27	100.0	41	100.0
Number Mental Hospitalizations [3, 4]						
0	8	72.7	25	65.8	34	69.4
1	2	18.2	11	28.9	8	16.3
≥2	1	9.1	2	5.3	7	14.3
TOTAL	11	100.0	38	100.0	49	100.0
Total Days in Hosp. after Key Release [3, 4]						
0	8	72.7	25	65.8	34	70.8
1-29	2	18.2	6	15.8	5	10.4
≥30	1	9.1	7	18.4	9	18.8
TOTAL	11	100.0	38	100.0	48	100.0
Work Status at 6 months [1, 2]						
Working (fulltime or parttime, in school, at home)	2	28.6	11	50.0	6	20.0
Not Working	5	71.4	11	50.0	24	80.0
TOTAL	7	100.0	22	100.0	30	100.0
Weekly Social Interaction Outside the Home and Outside Work [1]						
0	0	-	0	-	1	11.2
1-6	2	100.0	5	38.5	4	44.4
≥7	0	-	8	61.5	4	44.4
TOTAL	2	100.0	13	100.0	9	100.0

TABLE 2 Continued

	Release (N=11)		OPC (N=38)		IVH (N=50)	
	N	%	N	%	N	%
Any Dangerous Behavior During 6 Months [3, 4]						
No	9	81.8	26	68.4	35	71.4
Yes	2	18.2	12	31.6	14	28.6
TOTAL	11	100.0	38	100.0	49	100.0
Number of Arrests [5]						
0	11	91.7	64	92.7	79	94.0
1	0	-	4	5.8	4	4.8
>2	1	8.3	1	1.5	1	1.2
TOTAL	12	100.0	69	100.0	84	100.0
Number of Visits to the CMHC* [4]						
0	2	20.0	2	5.3	16	33.3
1-5	3	30.0	7	18.4	20	41.7
>6	5	50.0	29	76.3	12	25.0
TOTAL	10	100.0	38	100.0	48	100.0
Any Medication Refusal During 6 Months [4]						
No	0	-	9	31.0	7	31.8
Yes	7	100.0	20	69.0	15	68.2
TOTAL	7	100.0	29	100.0	22	100.0
Any Other NonCompliance During 6 Months [4]						
No	0	-	9	29.0	1	6.7
Yes	5	100.0	22	71.0	14	93.3
TOTAL	5	100.0	31	100.0	15	100.0
In Treatment at CMHC at 6 Months* [4]						
No	6	54.5	6	15.8	26	55.3
Yes	5	45.5	32	84.2	21	44.7
TOTAL	11	100.0	38	100.0	47	100.0

*$p<.001$, by X^2 Test

@Sample size for each outcome varies depending on data source and missing information within each source.

1. Data from telephone interviews with respondents
3. Data from mental health center, hospital, medical records
4. Data from mental health center, hospital, medical records
2. Data from telephone interviews with respondents' relatives/friends
5. Data from court records, district and superior courts were obtained on all members of the sample regardless of informed consent

TABLE 3: SIX MONTH OUTCOME FOR TARGET GROUP BY REALITY OF OPC

	ALL ASSIGNED OPC (N=38)		BEGAN OPC (N=31)	
	N	%	N	%
Residence [1, 2]				
Home (with family, friends, alone)	11	40.7	10	50.0
Group Home	1	3.7	1	5.0
Institution (mental hospital, nursing home	14	51.9	8	40.0
Jail	1	3.7	1	5.0
TOTAL	27	100.0	20	100.0
Number Mental Hospitalizations [3, 4]				
0	25	65.8	23	74.2
1	11	28.9	7	22.6
≥2	2	5.3	1	3.2
TOTAL	38	100.0	31	100.0
Total Days in Hosp. after Key Release [3, 4]				
0	25	65.8	23	74.2
1-29	6	15.8	3	9.7
≥30	7	18.4	5	16.1
TOTAL	38	100.0	31	100.0
Work Status at 6 months [1, 2]				
Working (fulltime or parttime, in school, at home)	11	50.0	8	47.1
Not Working	11	50.0	9	52.9
TOTAL	22	100.0	17	100.0
Weekly Social Interaction Outside the Home and Outside Work [1]				
0	0	-	0	0
1-6	5	38.5	4	33.3
≥7	8	61.5	8	66.7
TOTAL	13	100.0	12	100.0

TABLE 3, Continued

	ALL ASSIGNED OPC (N=38)		BEGAN OPC (N=31)	
	N	%	N	%
Any Dangerous Behavior During 6 Months [3, 4]				
No	26	68.4	24	77.4
Yes	2	31.6	7	22.6
TOTAL	38	100.0	31	100.0
Number of Arrests [5]				
0	64	92.7	27	87.1
1	4	5.8	3	9.7
>2	1	1.5	1	3.2
TOTAL	69	100.0	31	100.0
Number of Visits to the CMHC [4]				
0	2	5.3	0	0
1-5	7	18.4	5	16.1
>6	29	76.3	26	83.9
TOTAL	38	100.0	31	100.0
Any Medication Refusal During 6 Months [4]				
No	9	31.0	8	36.4
Yes	20	69.0	14	63.6
TOTAL	29	100.0	22	100.0
Any NonCompliance During 6 Months [4]				
No	9	29.0	10	40.0
Yes	22	71.0	15	60.0
TOTAL	31	100.0	25	100.0
In Treatment at CMHC at 6 Months [4]				
No	6	15.8	2	6.4
Yes	32	84.2	29	93.6
TOTAL	38	100.0	31	100.0

@Sample size for each outcome varies depending on data source and missing information within each source.

1. Data from telephone interviews with respondents
3. Data from mental health center, hospital, medical records
4. Data from mental health center, hospital, medical records
2. Data from telephone interviews with respondents' relatives/friends
5. Data from court records, district and superior courts